Strategic Planning Committee
February 8, 2012
4 p.m.
Scott Heyman Conference Room

Present:

Don Barber, Chair, Greater Tompkins County Municipal Health Insurance Consortium
Travis Turner, Executive Director, Physicians Hospital Organization
Steve Locey, Locey and Cahill and Consultant to the Greater Tompkins County Municipal Health Insurance Consortium
Betty Falcao, Director, Health Planning Council
Beth McKinney, Cornell Wellness Program
Jackie Kippola, Tompkins County Administration
Ken Harris, Administrator, Guthrie Clinic, Hanshaw Road
Elizabeth Karns, Village of Cayuga Heights Trustee
Steve Thayer, City of Ithaca Controller
Beverly Chin, Health Planning Council
Paul Bursic, Cornell University Human Resources
Laura Shawley, GTCMIC Board of Directors, Town of Danby
Mary Ann Sumner, GTCMIC Board of Directors, Town of Dryden
Dr. Matthew Estill, Primary Care Physician and Ithaca Guthrie Medical Director
Jed Constantz, Healthcare Consultant, CNYMSS
Eric Denk, Healthcare Consultant, CNYMSS

Call to Order

Mr. Barber called the meeting to order at 4:00 p.m.

Ms. Falcao distributed information on a Diabetes Self-Management Workshop that will be held. This is an evidence-based 6-week course that will help with skills needed to manage Diabetes as well as provide information on ways to continue to live a healthy life. Dates were not available; she will provide information on when the course will be held at a later time.

Mr. Barber said at the last meeting there was discussion of claims data and using the data to become more efficient with healthcare in the future. As a result of that discussion Ms. Karns asked if the Committee could drill down data for a particular illness. Mr. Locey said some of the data on the medical plan they are able to drill down to in the Excellus system was shared at the last meeting. Locey and Cahill are trying to integrate that data with Medco claims data but are having difficulty with particular illnesses, such as diabetes. He has questions with regard to whether the data being captured only includes one of the related diagnoses and putting everything in that "bucket" as opposed to spreading claims out to other diagnoses the person has, such as hypertension.

The other problem they are having is the one piece of information that is not captured by Medco on the prescription claims data is diagnosis. Mr. Locey said the fact that vendors the Consortium is dealing with are not capturing data in the same way is one of the challenges with this project and what makes it intriguing is to have the medical community involved. Mr. Turner said each insurer is using a different system to collect data. Ms. Karns noted they have a different objective than the Consortium and are not interested in managing costs.

Dr. Estill said chronic conditions such as hypertension and diabetes that lead to major illnesses or emergency room visits over several years may not show up as a high cost; however, high costs for cardiovascular disease are attributable to those conditions. Mr. Locey said part of the discussion at this meeting will need to be of how to get to the point to see where the true dollars are being spent in areas where there can be influence over.

Mr. Barber asked if Medco or Excellus has the capability to provide the information through their software programs. Mr. Turner said they are limited to what they have by an infrastructure perspective and are only interested in providing it in an aggregate form and it is not actionable data. Mr. Locey said part of the problem is in how Excellus receives and tracks the information and doesn't know that they have ever been asked to provide more or to capture the data differently. Mr. Bursic noted Medco does not receive diagnosis information; however, Excellus does have the information.

Ms. Sumner asked if anything in the Affordable Healthcare Act would cause any of the vendors to move in that direction if the goal is related to patient outcome. Mr. Locey said he is not aware of any provisions that would require insurance companies to do more, however, there are provisions that are wellness driven that employers can use as tools to try to move towards wellness. Mr. Bursic said the Act tries to create new awareness and demand for better data and for better tracking and outcomes; however, there are no financial incentives built into that. Ms. Falcao asked if it would be possible to look at a small group of individuals and do a study to gain an understanding of the process and to see where all the different levels of care are. Mr. Turner said it wouldn't be possible for this group to get the clinical information without identifying the patient. Ms. Karns suggested selecting individuals randomly and following the paid claims data.

Mr. Constantz recommended a different approach. He said Excellus can provide a random selection and through an attribution-type of analysis the primary care provider would be identified. The next step would be to work collaboratively with either CAP or Guthrie and ask them through a de-identified side, to give a presentation concerning how effectively each of the practices were in effectively treating the people. It is still possible some services obtained outside would not be able to be identified. Mr. Constantz said a look would also be taken at the claims data. The Consortium would need permission from the individual member whose claims they are and everyone would have to buy into the value of the practice, which he thinks is extremely valuable. A suggestion was made that people could volunteer to have their claims data analyzed. Mr. Locey said this would not identify people who are not going to the doctor who should be. Ms. Falcao said the benefit she sees in performing this exercise is that it may provide the Committee with a better sense of where to look in this data and how to try to pull things together around individuals.

Mr. Locey said one of the reasons this Committee was formed was to figure out how each part of the system can influence the other and to develop a way to attack the problem from everyone's individual perspective to get to a lower cost trend.

Mr. Turner said over the last several years they have been working on NCQA (National Committee for Quality Assurance) Accreditation, and now have 12 out of 16 practices accredited. He said what they are trying to do through CAP and their network of physicians along with the Hospital, is gather information and making it readily available at the point of care at the provider's side, and making it meaningful and actionable so they can use the information. Their three-part aim is to provide better care, provide better outcomes, and do so at a lower cost. He said by incorporating Clinical Integration into that methodology they are looking to do that with point of care, care management, disease management, a patient portal, and a provider portal into this infrastructure.

Mr. Turner said the type of infrastructure found across individual insurance companies is different. When you look at it from a provider perspective providers have to act differently for each individual insurance company, based on what the benefit plan design is and utilization the insurance company is trying to impose on them for treatment of care. With CAP's system they are trying to be payer agnostic so that the provider community can act on a single EHR

(Electronic Health Record) that gathers information that insurance companies now have. From the paid claims side they are trying to gather that information and feeds into the EHR so that it is a common EHR across all practices. Right now there are 47 practices with multiple EMR's (Electronic Medical Record) and none of them are integrated or "talking to each other". This is what CAP is attempting to do with Clinical Integration. Having the 30 specialties and 47 practices all using a common EHR is what is now known as Active Health.

Mr. Turner explained how this is incorporated at the practice level and said there is a provider portal where providers are able to access paid claims data regardless of where the service was provided. They have access to prescriptions that have been written based on the PBM (Prescription Benefit Manager) data that has also been loaded into the system. Eventually they would like to add lab data.

The infrastructure called Active Health is different from what insurance companies are doing because it is payer agnostic. They are now going to accept every employer's data and are working collaboratively with employers directly. Mr. Turner said it is an expensive infrastructure and a lot of work. They have been working on this for the last 22 months and now have 180 physicians in the network and 15 different practice management vendors, six EMR (Electronic Medical Record) vendors, the hospital information system, and the community of insurers, along with the community of employers. They have had discussions with Cornell, Ithaca College, Borg Warner, the Ithaca City School District, and this Consortium, which are the largest self-insured employers in Tompkins County. This is being done in response to Health Care Reform and to continually increasing health care costs. In the end the goal is to provide better health care, more accurate health care with better outcomes, and to bend the medical cost curve.

Through this system information will be available to inform a physician whether or not a prescription that has been written has been filled; this information is not currently available.

Mr. Turner said once information is collected in the system there can then be discussion about utilization at the point of care and provider level. It would also provide information to the provider that a patient may not be forthcoming about.

Mr. Harris asked how out-of-network medical treatment gets into these records. Mr. Turner said the employer is releasing the data through the paid claims side. Dr. Estill said this is an enormous amount of work and very expensive. He said Guthrie did this in 2009 by having an electronic record across its system, and it greatly changes the workflow for the primary care provider by having access to data that is needed to make decisions.

Mr. Locey said it would be interesting if the PBM could include information on the cost of a medication. Although a decision shouldn't be made solely on cost, if there are two drugs that could be chosen the provider would know which was lesser in cost.

Mr. Bursic asked Dr. Estill to describe the progress Guthrie has made and whether it has led to better patient care and better-coordinated care. Dr. Estill said it helps to have all of the information available in one screen and stated that it has certainly helped with quality of care. To have the integration within Guthrie and to have all of the physicians aligned along common organizational goals has also helped.

Ms. Karns asked if Dr. Estill has noticed anything in terms of outcome changes, such as less emergency room visits for example. Dr. Estill said they have done some outcome measures around quality of care data and have been doing a good job in that area. They have not seen cost data yet.

Mr. Locey noted that although employers would like to see better healthcare the driver behind engaging in these discussions is the need to lower healthcare costs.

Ms. Falcao raised the issue of the Consortium's role in terms of members. Mr. Locey said the Consortium is trying to figure out the best way to deal with the costs and looking at what types of benefit design needs to be put into place to facilitate the things such as what CAP is trying to accomplish. Using the drug benefit as an example, he questioned what the most efficient level of co-pay is to make sure members get the types of prescription drugs they need to be treated in the way the physician wants them to be treated and to drive the usage in the right direction. He said there are several different plan designs within the Consortium and questioned whether if the medical community has the information in terms of the costs, they could be the stewards in watching the costs.

Mr. Turner spoke of the drug fill rate and said every provider they know of in the community is roughly in the 70% range; in a clinically integrated network they are in the 85%+ range. The only way the employer can drive that is through benefit plan design and co-pays. Mr. Locey said the Consortium is in the 65% range. He spoke of the shift in healthcare costs and said the volume has gotten bigger in terms of what is being spent in healthcare dollars. Approximately 15 years ago drug expenses were close to ten percent of expenses and today it is 30 percent or greater for most plans. Doctors used to receive approximately 25 percent and now are down to close to ten percent.

Mr. Barber raised the question of how to get patients engaged and said he hopes there can be further discussion of this that will include wellness programs.

Ms. Sumner asked if a message will be framed for employees to embrace this concept; she also said buy-in by the employees is one way to drive the process. Mr. Turner said they have not seen resistance from patients and that bringing them into this is part of the process is done through the patient portal.

Mr. Turner addressed how Clinical Integration is being funded and said it is funded through the providers and the Hospital.

Dr. Estill said he has seen a lot of resistance from patients in getting them into the system. They have an incredible benefit package available to them but Guthrie still has to work very hard to get them to even come in for a wellness visit.

Mr. Bursic does not want the impression to be that the only thing that is important to employers is the cost. The health of employees is also very important; he said studies have shown that if an organization has healthy employees and healthy family members, employees are happier and more productive and excited about doing things. He said there has to be a commitment that wellness is important. That is a start to help people begin to get the impression that good health is a personal responsibility. He also noted that there is a lot of wellness opportunities available.

Ms. McKinney said she thinks employees will become resistant if they think the employer is asking for personal information; they are usually comfortable when it is the medical community because they know providers are required to follow the HIPPA rules. Dr. Estill and Mr. Harris said they have seen tremendous success with the patient portal and that patients like to be able to access their own medical information.

Next Meeting

Ms. Karns said she would like to see actual numbers at the next meeting and to begin setting goals for the next couple of years. She said it also helps her to know what the per capita cost is.

Mr. Turner said he can share aggregate CMS data of costs for Tompkins County within the delivery model as compared to other counties in New York State and nationally. Not only will it include all of inpatient care for CMS (Medicare and Medicaid), but also three days prior to care and thirty days after care. Tompkins County has been shown to be below the average for both the State level and the national level. Mr. Locey asked if there is some data he can provide that is relative to the Consortium that would contrast between the two organizations. Mr. Turner said they can take three years of prior Consortium data from Excellus and run it through their system. They would look at the predictive model to find where the high risks are and look at the potential of what they can do just on reporting with their tools through Clinical Integration alone. This process will not have any cost but will take approximately one month to complete and require the Consortium to release the data.

Dr. Estill said another high-risk area that Guthrie is looking at is hospital re-admission after 30 days of discharge. CMS is going to require this and most hospitals are already gathering this information. He suggested the Consortium could look at this also.

Recommendation

It was the consensus of those present that it is the Committee's recommendation that the City and County data be run through the Active Health system for the purpose of trying to identify where particular high-cost drivers are.

Next Meeting

Ms. Falcao briefly reported on complimentary systems that exist to communicate with the public about wellness opportunities. Dr. Estill said he can provide information about a Borg Warner's on-site wellness efforts that have working well. Mr. Barber will coordinate with Ms. Falcao and Dr. Estill on bringing information back to the next meeting. Ms. Falcao asked Mr. Turner to bring back information on what factors can be expected out of the report from Active Health.

Adjournment

The meeting adjourned at 5:42 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk